

Vermont Department of Disabilities, Aging and Independent Living

Choices for Care - Enhanced Residential Care Service PlanParticipant Name: _____ Soc. Sec. # _____ - _____ - _____
(Please Print)Services Provided in: _____
(Town)☐ Initial Assessment ☐ Reassessment ☐ Change
Start Date: _____

Primary Diagnosis: _____

ICD-9 Code: _____

Service	Provider (Write in provider name)	Hours of Service	Rates	Cost/Month
<input checked="" type="checkbox"/> Case Management	<input type="checkbox"/> AAA: <input type="checkbox"/> Home Health:	Up to: 48hrs/yr	\$67.44hr	\$269.76
<input checked="" type="checkbox"/> Enhanced Residential Care	ERC Provider Name:	24 hrs/day 7 days/wk	TIER 1 \$48.76/day RCH \$53.95/day ALR \$1467.68/mon RCH \$1623.90/mon ALR	
		24 hrs/day 7 days/wk	TIER 2 \$55.51/day RCH \$60.69/day ALR \$1670.55/mon RCH \$1826.77/mon ALR	
		24 hrs/day 7 days/wk	TIER 3 \$62.25/day RCH \$67.44/day ALR \$1873.73/mon RCH \$2029.94/mon ALR	
Total Monthly Cost:				

Services Not funded by Choices for Care – Formal Services (indicate funding source)

Services	Service Provider	Funding Source	Frequency	Cost per Month
<input checked="" type="checkbox"/> ACCS		MEDICAID	DAILY	
<input checked="" type="checkbox"/> Room & Board		SELF	MONTHLY	
<input type="checkbox"/> Skilled Nursing				
<input type="checkbox"/> PT/OT/ST				
<input type="checkbox"/> Hospice				
<input type="checkbox"/> Other				

Department of Disabilities, Aging and Independent Living Authorization/Official Use Only

Services are authorized effective: Start Date: _____ through End Date: _____
(A full reassessment must be completed prior to the end date in order for ERC services to continue.)

DAIL Authorized Signature _____

Date _____

CONSENT TO PLAN OF CARE

I, _____, have been fully informed of the proposed **SERVICE PLAN** and understand the terms as described in this **Service Plan**. I consent to this plan and accept it as an alternative to the Home-Based or Nursing Home setting.

► _____ Date: _____
Signature of applicant/participant or legal representative

► _____ Date: _____
ERC Provider Signature

_____ Agency: _____ Phone #: _____
Case Manager Name/Print

► _____ Date: _____
Case Manager Signature

NOTE: All Plans must be signed by applicant/participant or legal representative (Power of Attorney or legal guardian), Case Manager, and ERC Provider in order for services to be authorized.

Service Plan Changes: Complete a new Service Plan and briefly describe the reason for change. (Attach supporting information.)

Important Information

Appeal Rights: See attached letter if services were reduced or denied by DAIL.

Changes: The individual or legal representative must report all changes in status to the ERC provider and the case manager.

Patient Share: Refer to the Department for Children and Families (DCF) Notice of Decision for patient share amount (if any) and for the provider that the patient share is to be paid each month.

Provider Billing: Providers must retain a copy of the current approved Service Plan as authorization to bill for services. Providers may only bill for services provided within the limits indicated on the Service Plan.

Reassessments: Annual reassessments will start on the date after the previous Service Plan ends.

Service Plan Changes: Approved Service Plan changes will start no earlier than the date the Service Plan is received at the DAIL regional office.